



# Authorization for Release of Medical Records

Please mail or fax requests to: Austin Radiological Association / Image Library, 3301 West Avenue, Austin, TX 78705  
Phone: 512.719.8230 Fax: 512.837.2105

**Type of record requested**

**Date of Request:** \_\_\_\_\_

- Radiograph (Film)  Radiograph (CD)  Diagnostic Report  Designated Record Set  Billing Record

**Patient Information**

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ MRN: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Name of Parent/Legal Guardian: \_\_\_\_\_

**Exam Information**

Date of Exam: \_\_\_\_\_ Type of Exam: \_\_\_\_\_  
ACC: \_\_\_\_\_ For Multiple Exams, Date Range (from): \_\_\_\_\_ (to): \_\_\_\_\_

**Who is requesting release of Medical Records?**

- Patient  Patient Representative  Physician  Hospital  Freestanding Imaging Center  Legal Representative  
 Other \_\_\_\_\_ **Name of Requestor:** \_\_\_\_\_

**Reason Requesting Medical Records:**  Continued Medical Care  Part of patient's treatment team

- Patient will "hand carry" records to physician office  Other \_\_\_\_\_

**Patient Signature** - Authorization for Austin Radiological Association to Release Records documented on this form

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Where is ARA to send requested Medical Records?**

- Mail  Fax

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Will records be picked up?**  Patient  Patient Representative  Courier Service  Legal Representative

- Patient Designee as noted below

I \_\_\_\_\_ (patient name), grant access to pick up the medical records documented on this form to \_\_\_\_\_ (name and relationship to patient).  
Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

**For internal use only:**

Date Records Released: \_\_\_\_\_ Verification of ID Completed  Yes ARA initials \_\_\_\_\_

Who is picking up the records? ( Complete only if records are picked up )

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

In signing this form, I understand and accept full responsibility for the medical records (i.e. confidential information) I am about to receive. I relinquish Austin Radiological Association of any and all accountabilities concerning these medical records. I understand that I have the right, per HIPAA §164.508, to revoke this authorization in writing by sending written notice to: Attention: Privacy Officer, Austin Radiological Association, P.O. Box 4099, Austin, TX 78765. I understand that a revocation is not effective to the extent that Austin Radiological Association has relied on the authorization to disclose protected health information; and I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

**THIS FORM IS NOT VALID 1 YEAR BEYOND DATE OF REQUEST. DATES AND SIGNATURES ARE REQUIRED.**

We are allowed to charge you a reasonable fee to cover our costs for making copies of digital images and may charge for multiple copies of paper records.